Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 05/08/01 through 07/18/01.
   b. The request was received on 06/12/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Position Statement located on the Table of Disputed Services
   b. HCFAs-1500
   c. TWCC-62 forms
   d. Example EOBs from other carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. TWCC-62 forms
   c. Example EOB from the carrier to other providers/Methodology
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/08/02. Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/10/02. The response from the insurance carrier was received in the Division on 07/17/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
"Chronic Pain Management is billed as code 97799-CP for each day and the number of hours spent in the program is indicated on the bill…. (Provider's) usual and customary fee for these services is $180.00 per unit (hour)…. (Provider) objects to the…denial codes and descriptions. First, (Carrier's) statements are not sufficiently explanatory to enable (Provider) to fully respond, thereby, denying (Provider) of his due process rights guaranteed under both the Texas Constitution and the United States Constitution…. (Provider's) usual and customary fee is $180.00 per hour. Since they are not yet CARF accredited, they do expect to only be reimbursed at 80% of their usual and customary fee."

2. Respondent: Letter dated 07/15/02
"Pain management programs are structured to provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning and decrease the dependence on the health care system. (Carrier) reimburses these services at a fair and reasonable rate of $125 per hour rate for an accredited provider and $100.00 for a non-CARF accredited facility. This is the result of extensive review of all identifiable Chronic Pain Management Programs across the state of Texas. All contacted providers found our consistent reimbursement of $125 per hour to be acceptable. From information obtained from these providers, a 'standard' CPM program was identified and evaluated at a 'per modality' rate according to the Texas Fee Guidelines. Based upon that review, the per hour reimbursement would be $116.00. Our $125 rate allows an additional $9.00 per hour to cover the cost of Medical Management, Case Coordination etc. Attached documentation illustrates our consistent reimbursement of this rate…."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/08/01 through 07/18/01. Dates of service 05/17/01 and 05/21/01 are being dismissed.

2. The carrier's EOB exception denial are:
"F- REDUCTION ACCORDING TO MEDICAL FEE GUIDELINES";
"M- Z436 (F) CHRONIC PAIN MANAGEMENT";
"F -Z560 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY (auditing company.";
"D – DUPLICATE CHARGE";
"D – U301 THIS ITEM WAS PREVIOUSLY SUBMITTED AND REVIEWED WITH NOTIFICATION OF DECISION ISSUED TO PAYOR/PROVIDER (DUPLICATE INVOICE)";
"M – REDUCED TO FAIR & REASONABLE."
"O –X598 CLAIM HAS BEEN REEVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE."

The provider states that their usual and customary charge is $180.00 per hour and do expect to be reimbursed 80% of their usual and customary fee. Therefore, the 20% reduction for a non-CARF facility would be $144.00 per hour. In review of the provider's Table of Disputed Services, the provider billed services for $180.00 and $185.00 per hour. The provider does not give a reason for billing two different charges for the Chronic Pain Management Program. Therefore, the lower charge of $144.00 per hour will be used to determine reimbursement.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Codes	MAR$	REFERENCE	RATIONALE:
05/08/01 05/09/01 05/10/01 05/11/01 05/14/01 05/15/01 05/22/01 05/23/01 05/24/01 05/25/01 05/29/01 05/30/01 05/31/01 06/01/01 06/04/01 06/05/01 06/06/01 06/07/01 06/08/01 06/11/01 06/13/01 06/15/01 06/18/01 06/19/01 06/20/01 06/21/01 06/22/01 07/18/01	97799-CP	$900.00-5 units $720.00-4 units $900.00-5 units $925.00-5 units $740.00-4 units $925.00-5 units $935.00-5 units $925.00-5 units $925.00-5 units $185.00-1 unit $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $925.00-5 units $1,110.00-6 units $925.00-5 units $1,110.00-6 units $1,110.00-6 units $1,110.00-6 units $185.00-1 unit	$500.00 $400.00 $500.00 $500.00 $400.00 $500.00 $500.00 $500.00 $500.00 $100.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $500.00 $600.00 $500.00 $600.00 $600.00 $600.00 $100.00	F F D,F F F, MZ436,FZ560 F, MZ436,FZ560 F, MZ436,FZ560 F, MZ436,FZ560 **M**,MZ436,FZ560 D,MZ436,FZ560 F,OX598,MZ436 D,MZ364,FZ560 D,MZ436,FZ560 **M,**MZ4366,FX560 F,MZ436,FZ360 F,MZ436,FZ560 F,D,MZ436,DU301 F,MZ436,FZ560 F F **M**,FZ560,MZ436 F,MZ436,FZ560 F,MZ436,FZ560 F,MZ436,FZ560 F F,MZ436,FZ560 **M**, MZ436,FZ560 **M**,F	DOP	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i) & 133.307 (g) (3) (D); Rule (j) (1) (F); Rule 133.304 (c); MFG MGR (II) (C) (G); MFG GI (VI); CPT descriptor	The provider included in their dispute packet, documentation (EOBs from other carriers) that does provide some evidence of "fair and reasonable" reimbursement. The provider is a non- CARF accredited facility, therefore, the reimbursement rate will be reduced by 20% less than the maximum allowed reimbursement. The Medical Review Division reviewed the file to determine which party has provided the most persuasive evidence of what is a fair and reasonable fee. The carrier submitted the methodology it used to determine fair and reasonable reimbursement. The carrier submitted five EOBs to support their methodology and how they consistently reimbursed providers at their fair and reasonable rate. The provider submitted EOBs that do show some evidence of fair and reasonable. For those dates of service denied by exception code "M-Fair and Reasonable", the carrier presented the more persuasive documentation discussing, demonstrating, and justifying that the amount paid for the codes denied "M" only that the provider was paid a fair and reasonable rate of reimbursement according to Texas Labor Code Rule 413.011, 133.1, and 134.1. **The dates of services of 05/24/01, 06/01/01, 06/13/01, 06/22/01, and 07/18/01** will be not be recommended for reimbursement. For dates of service denied by exception codes "MZ-436, F-Z560, DU-301, and F" the carrier failed to submit exception denial codes per Rule 134.304 (c) which states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)…" The carrier failed to submit explanation of benefits which included the correct payment exception codes required by the Commission's instructions. The provider was not given sufficient explanation to allow the provider to understand the reason for the denial. CPT code 97799-CP is a DOP procedure which has no MAR value. CPT for which there is no MAR value shall be reimbursed at the fair and reasonable rate.

							The provider stated that their usual and customary fee for CPT code 907799-CP is $180.00 per hour (unit). To calculate proper reimbursement, $144.00 per hour will be reimbursed to the provider ($180.00 x 20% = $144.00 per hour). The carrier reimbursed the provider $600.00 for 6 hours at $100.00 an hour, therefore leaving reimbursement in the amount of $264.00 due for each date of service where the provider billed for 6 hours. Where the carrier reimbursed $100.00 for one hour of service, $44.00 is due to provider. The provider billed for 4 hours of service, which equals $576.00 at the rate of $144.00 an hour. Reimbursement in the amount of $176.00 is due for each date of service where the provider billed for 4 hrs. The provider billed 5 hours of service, which equals $720.00 at the rate of $144.00 per hour. Reimbursement in the amount of $220.00 is due for each date of service where the provider billed for 5 hours. The provider is entitled to a total of **$2,728.00** for the listed dates of service., except 05/24/01, 06/01/01, 06/13/01, 06/22/01, and 07/18/01. (112 hours billed @ $144.00 = $16,128.00 - $13,400.00 carrier paid = $2,728.00 due to provider).
Totals		$24,720.00	$13,400.00				The Requestor **is** entitled to additional reimbursement in the amount of **$2,728.00.**

The above Findings and Decision are hereby issued this 11th day of March 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $2,728.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 11th day of March 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

CO/dmm

VI. Dismissal

Dates of service 05/17/01 and 05/21/01 are being dismissed. According to Commission Rule 133.307 (m), the Division may dismiss a request if the commission determines that good cause exists to dismiss the request. Rule 133.307 (e) (1) (C), states that the initial request for medical dispute resolution submitted by the provider shall include a Table of Disputed Services listing the specific health care and charges in the form, format, and manner prescribed by the commission…."

The Table of Disputed Services for dates of service 05/17/01 and 05/21/01 lists the amounts billed for CPT 97799-CP as $740.00 and $1,110.00, respectively. The HFCA for date of service 05/17/01 indicates the provider billed 6 hour at $1,110.00 for CPT code 97799-CP. The HCFA for date of service 05/21/01 indicates the provider billed 4 hours at $740.00 for CPT code 97799-CP.

It is the conclusion of the Medical Review Division that this case be dismissed without any additional action being taken at this time.

The above DISMISSAL is hereby issued this 11th day of March 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm